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ABSTRACT

Elderly clients resistant to help present an ethical dilemma for professionals. This dilemma may climax when assumption of authority over the client for his safety is necessary. Social workers need to work for decisions closest to the wishes of the client. The at-risk client should be informed about changes that will occur and how these changes will help him in order to reconcile the client to these changes. A client may resist assistance because he feels it is interference and signifies the loss of his integrity as a person. The client may defend himself against protective help by opposing changes in his environment, minimizing his problems, blaming outside causes for his discomfort, and manipulating another person to supply his needs. The objective for a social worker is to reconcile his and his client's goals. This can be facilitated by an empathetic relationship and by the social worker's acceptance of the client's choice of alternatives. If the client's cognitive abilities do not support this, a trusting therapeutic relationship must be substituted. Skill and patience with the resistant client are of utmost importance. (ABL)

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CLINICAL ASPECTS OF ASSESSMENT AND INTERVENTION WITH RESISTANT CLIENTS

Social Worker and Client Values

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CLINICAL ASPECTS OF ASSESSMENT AND INTERVENTION WITH RESISTANT CLIENTS

Social Worker and Client Values

The preceding papers in this trilogy* have discussed the at-risk aged client population, the problems they present in resisting social work help, and the ethical issues and social values involved in attempting to overcome or override their objections to necessary changes and the introduction of protective measures. The resolution of this professional ethical dilemma has been clarified as achieving a parallel between the increasing personal risk to impaired and resistant aged clients and the worker's increasing professional responsibility and assumption of authority for social intervention.

The values and standards taken by other professions is an additional complication in resolving social work action when others, not we, will make decisions affecting the lives of our disruptive, uncooperative, frightened elderly. Where it is necessary for others to take charge of their vulnerable lives, we need to make known more surely our unique ability to help frail and resistant clients in such precarious circumstances. At least we can try to help them reach an understanding of what is to happen to them, why we think it will help them, and to reconcile with it, before drastic life-changing action for protective changes is taken. Where choices are possible, we need the opportunity to elicit and then press for those alternatives closest to what is important to the client.

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*I. Hayes, C. The Resistant Client: Value Conflicts
II. Soniat, B. Model for Interdisciplinary Team Approach

The Client's Values

Our task is a touchy one. It is difficult enough to accept or support respect for the client's value system, and for his or her preference to forego changes and to accept risks so as to live out an uncertain life as he or she wishes. Supporting these wishes becomes even more complicated when the client's life is at immediate or impending risk and he/she refuses help - change - to ease or prolong it.[1] Any forcible action against one's will, contrary to our professed values of self-determination, is experienced as destruction of one's autonomy. Forcing changes in the client's life without deference to his ideas and emotions; without exploring his situation with him at the length he requires for understanding, considering, what is at stake, is then committing a minor atrocity. Yet may we with good conscience hold back on imposing lifesaving and easing measures which the client will come to welcome?

In these deliberations we need to be clear about what the resistant, difficult client values most in his life, and about our own professional values; and if they do not concur, we need to be clear about which should take precedence in arriving at a decision on his shortened future. We need to understand the basis for his resistance. Those clients with truly critical physical and mental disabilities affecting their survival certainly present the most acute dilemmas, but we should be equally concerned with the aged facing less critical but predictable decline, who may live longer and who have a longer investment in meaningful years. We can prevent or salvage more, get a better pay-off, with sensitive exploration of their hesitations and resistances to frightening changes in themselves and their needs.

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1. Author's Note: From here on I take refuge in Safire's dictum that "he and his can be gender neutral. We need not resort to awkward flip-flops to ward off suggestion that our average American is a transvestite by insisting on his/her." New York Times Magazine, May 26, 1985.

The impaired client's resistive behavior and its meaning for him will be explored in this paper. This exploration is seen as a guide to a logical casework approach effective in lowering the impaired client's resistance to planning, or to plans, for his own welfare. In addition to understanding his value system, other vital issues - the type and severity of his impairments and the intactness of his capacity to use judgment - are briefly addressed.

How Do Resistant Cases Arise?

It may be of interest to learn of a recent brief survey of 33 cases with multiple impairments, designated by their service agency as resistant to badly needed assistance at home to avoid a crisis. The cases were reviewed to ascertain their characteristics at application, whether there were evident factors predictive of subsequent resistance, and how practitioners responded to the client's state of mind. Two sources for these cases were used - 11 cases came from a professionally-trained case management staff dealing with aged persons living in the community, and 22 were residents in a city facility for the aged. Recorded summaries and brief questions of service staff were employed to obtain information. For our purposes some relevant observations are briefly enunciated here; the full report will be presented elsewhere.

In all the cases reviewed, referrals to the service agency were made by single-service providers such as homemaker agencies, visiting nurse services, community groups, or - in only two cases - by a concerned relative. None of the 33 clients who later turned out to be resistant, initiated the request for help.

It was apparent that these dysfunctional aged persons were inadequately involved in the inquiry for help made on their behalf, were uninformed about need to assess their problems; disinclined to face their increasing disabilities,

particularly with a stranger, nor prepared to discuss what to do about them. Shame, fear, and anger were generally evinced. It is impossible to say that initial refusals of professional offers of help of this sort are definitively predictable of continued resistance. It is likewise impossible to say that an unfavorable introduction will determine poor on-going working relationships.

The same observation can be made of differences in expressed goals between client and worker. Resistant client and worker's goals in seven community-based cases (based on information available) differed markedly: only two acknowledged any needs - one wanted money, the other, immediate fulfillment of irrational and impossible demands. (The other five cases in the group all expressed as their desire, no invasion of their privacy by the worker.) In contrast, the workers listed a total of 22 steps or goals to help improve the clients' situations.

It is possible that poor initial preparation of the clients to face their needs, and differences between client and worker in perceived needs, may characterize many case management problems and yet be overcome in the subsequent case process and interaction. It may be observed, however, on the basis of common sense, that such disparate intentions as expressed in the small number surveyed would seem to augur ill for a good continuing relationship. Additionally, the workers' pressures to initiate immediate changes in view of the dangers the clients faced, generally violates the primary psychological task to form a trusting relationship as the basis for any subsequent sustaining psychotherapeutic maneuvers together with the client. Abrupt changes are frightening.

With these brief examples in mind, we can now go on to examine resistance in aged and impaired clients as a phenomenon.

What Motives Underlie the Client's Resistance?

For purposes of this presentation, client resistance to considerations affecting his manner of living is viewed as a reaction to relinquishing control over his life. He balks at giving up charge of himself. The aged person undergoing personal dissolution of his resources to function, to manage, is struggling not merely with matters of external management, but with invasion of his integrity as a person, his sense of self, which he has established over a lifetime. Such dissolution is tantamount to facing death. Even small losses in capacity, small changes in his way of life, small decisions about minor matters, bear enormous implications to an already weakened and threatened person, and call up profound emotionality. Any intervention is the very embodiment of the changes he fears, and we cannot forget that one of the dictionary synonyms for "intervention" is "interference." To the client who infuriatingly but pathetically resists our invasion into his disintegrating life, we appear not as the rescuer but as the destroyer. He can voice his sense of our invasion more cogently and keenly when his impairments are physical rather than mental, although in either case the feeling may be equally acute.

How Does the Resistant Client Defend Himself?

As the person's internal and external sense of mastery and of realistic control disintegrate, he attempts to marshall and organize his defenses against our takeover, to protect himself from the dangers he perceives. He makes efforts to reassert himself as commander of his own life by suppressing the importance of his incapacity to manage independently or to get along even with extensive help. We think we are concerned with saving him; he is concerned with saving himself from us.

What Are His Defensive Maneuvers?

Under the pressure of either diminished mental acuity or physical capacity, the client executes a variety of emotionally driven maneuvers.[2] According to his personality and resources, these include:

- avoiding or resisting separation from his familiar environment, which would expose him to unknown stresses and demand too much of his shrinking vitality;
- finding external rather than internal causes to blame for his increasing discomforts—seeing his problem as deprivation rather than decline;
- searching for ways to commandeer resources to substitute for his own lost strengths—most often, in the form of a person whom he can manipulate to supply his needs as he dictates;
- passive refusal to participate in or contribute to necessary planning or action.

The following diagram presents the psychodynamic aspects of aged persons' attempts to cope with increasing impairments and issues of helplessness in the face of functional decrements with aging.

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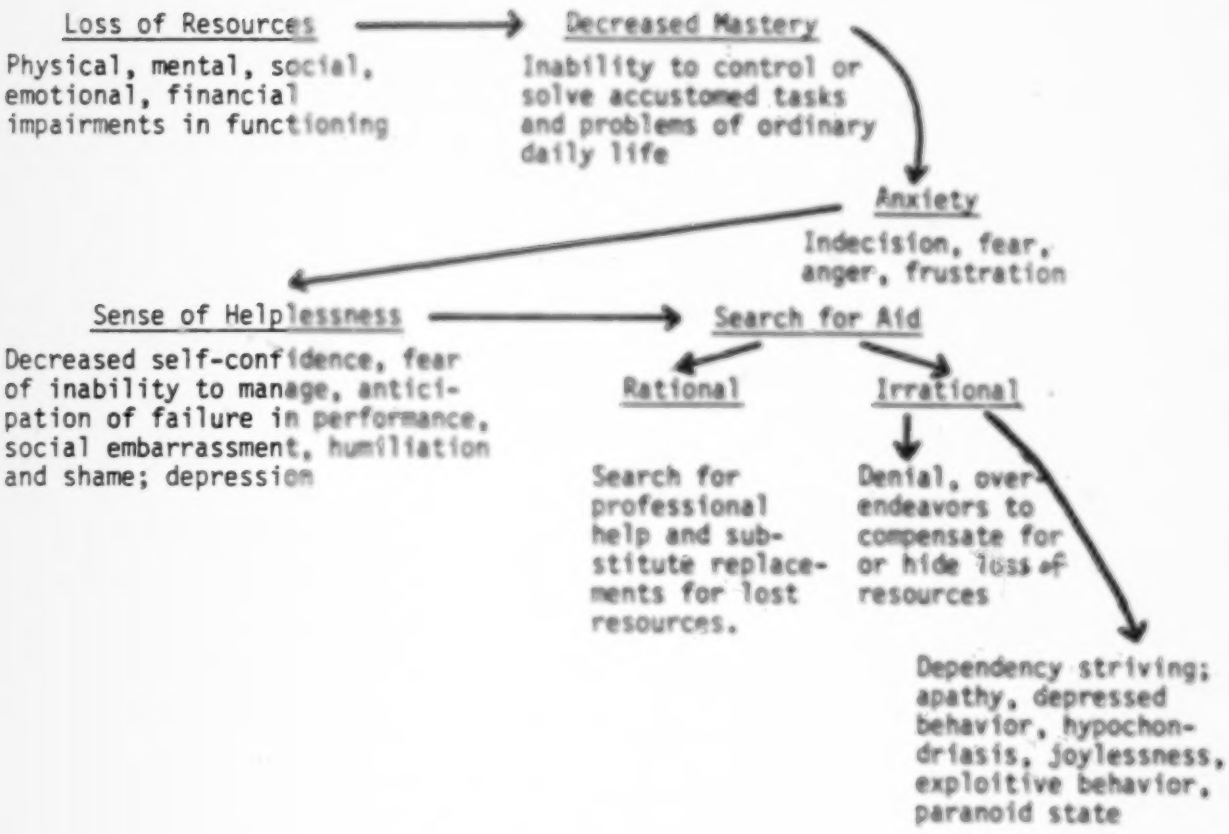
2. See Aronson, Miriam; Ruth Bennett; Barry J. Gurland: The Acting Out Elderly, Haworth Press, NY, 1983. Weiner, Sophie: p. 22; and Burr, H. T., Working With Mentally Impaired Center Members, in Working With the Impaired Elderly, NCOA, Washington, D.C., 1976.


Loss of Resources
Physical, mental, social, emotional, financial impairments in functioning
Decreased Mastery
Inability to control or solve accustomed tasks and problems of ordinary daily life
Anxiety
Indecision, fear, anger, frustration
Sense of Helplessness
Decreased self-confidence, fear of inability to manage, anticipation of failure in performance, social embarrassment, humiliation and shame; depression
Search for Aid
Rational
Search for professional help and substitute replacements for lost resources.
Irrational
Denial, over-endeavors to compensate for or hide loss of resources
Dependency striving; apathy, depressed behavior, hypochondriasis, joylessness, exploitive behavior, paranoid state

These coping methods need to be identified in dealing with resistant clients in order to employ the proper responsive dynamics therapeutically.

Such behaviors are the top layer to more profound dynamics the client plays out in reacting to the need for assistance, in his reluctance to acknowledge his increasing helplessness, and in his attempts to overcome his encroaching disabilities. We see all too often a parade of sad steps in reaction to growing powerlessness: attempts to maintain or control, through refusal to admit realistic deficits; angry demands, or manipulative passivity; shame and depression; grief over personal functional losses; disorganization, panic; and when all his defenses fail, abandonment of self-direction, collapse, negativism, suicidal lethargy and dementia. In this process, his search for aid is often tragically misunderstood.

Understanding the emotional basis for an individual's resistance is imperative to effective therapeutic response. Again, let us have recourse to definition. Resistance encompasses several behaviors, ranging from outright opposition, to withstanding pressures, to merely retarding or opposing movement or shifts in situations. Disordered behavior which seems irrational should not occupy our attention; rather we should go on to search for the underlying emotional reasons. In the face of fear, fight or flight occurs in some form. The strength of the client's resistance as well as the kind of resistance he puts up needs to be calculated in planning therapeutic strategies to reduce it.

Is the Resistant Client Always the Involuntary Client?

It is necessary to consider the type of disorder the client displays in resisting in order to determine the appropriate action to pursue.

- A distinction must be made between the legal judgment of incompetence and the mental health judgment of psychosocial incompetence which places the client in danger. This concern defines our function in relation to impaired clients.

We are here concerned with the client's social incompetence, incapacity to manage, to judge, to decide, to act, incapacities which require social protections of some sort.

- There is also a distinction between mental disorder and emotional disorder to be made in weighing social dysfunction. Advanced mental impairment or irrecoverable psychosis appear to be more clearly a basis for judging that the client may need institutionalized protection on his behalf than emotional disorder reactive to life stresses, which may be transient, episodic, or ameliorable, and often treatable.
- From our vantage point it is necessary to clarify the "involuntary" client. The dictionary defines "involuntary," interestingly, as: not done by choice, or not consciously controlled. It is <u>not</u> defined, even although as interpreted in some of our social work literature, as non-voluntary, or <u>against</u> one's will. There is a difference in not choosing to do something - merely withholding consent - and having it done against one's expressed will. In tussles with "involuntary" clients, we must not forget this distinction, even although in the end the responsibility and decision may fall on us. Sometimes a client's even reluctant acquiescence to arbitrary-seeming action is tacit agreement, success. Sometimes it may be necessary to accede to the client's primary right to refuse services or changes we support.

The significance of these differences for practice will be discussed at another time: the principle evoked here is that the type of disturbance of individual clients requires individual consideration, before we are free to take over life decisions for an elderly person, be he client, friend or relative. Diagnostic, interpretive and communicative skills are needed for this transaction. The development of those skills requires supervised internships, which test learning and crystallize informational methods of teaching through practice.

What Approaches Can Overcome Resistance?

What the social worker aims for with the resistant client, however, is not manipulation but a reconciliation of his and the client's goals so the client can be helped to make hard choices and see his subsequent preferences carried out. There is a double professional charge: to ensure an adequate process of interchange, and to achieve, with the client, an outcome, a decision, closest to his basic wishes. Restoring emotional balance to the vulnerable, frightened client resistant to changes he fears must be achieved before he is able to think through with the social worker what he would choose of necessary changes. This is a sensitive task requiring therapeutic techniques and persistence, expensive in time and in skill. A consistent relationship of empathic concern which earns the confidence of the client is the first and most basic imperative necessary in work with the client's blind resistance.

It is important to defer to the client's choice of alternatives especially where his judgment is intact and he understands the consequences. It is also important to distinguish resistance to a change in situation from resistance to us as messengers of change. Sometimes just explanations of the need to move,

obtaining the client's ear and his grudging understanding, is a sufficiently deferential tactic to give him a feeling his consent is being asked and that he gives it. Respect for his autonomy and restoration of his sense of mastery over his own life can help reduce his anxiety and create the climate for more thoughtful, rational exploration of choices available to him.

With aged clients who have lost considerable self-confidence and actual cognitive capacities, however, we may find their coping methods so eroded or disorganized that they cannot act responsibly for themselves or participate in logical planning or decision-making. Rational approaches must then be deferred in favor of establishing a continuing therapeutic parental relationship in which the worker earns the trust of the client that the worker will protect him; with this continued protection he may safely assent to recommended changes even if he does not fully understand them. Where the client continues to react with panic or emotional paralysis, courting and winning his trust may at least reduce his open opposition to inevitable protective changes. Again, his acceptance of us may be tantamount to entrusting himself to us. An important part of the trust relationship is staying with him in an emotional sense throughout his difficult experiences, not abandoning him to others he does not yet trust or like.

In short, there is no way to deal therapeutically with resistance except by first recognizing the client's catastrophic crisis of dependency and helplessness, and by restoring his sense of personhood through our respect for his feelings and concern for his problems. The therapeutic parental relationship creates the balance point for shifting towards protective change in a mutual way. To work with the resistance of the client defying fate, a person in terrible trouble, is a rather different approach from viewing his resistance as a problem in management.

What of the Social Worker's Countertransference?

Ironically, we must acknowledge our own reluctance to take on a hard task as we deal with our client's resistances to social therapies. If events in crisis do not allow time or space to help a person work through his fears, we must still acknowledge them and pledge to see him through them and the external changes he must undergo as an "involuntary" client.

Professional objectivity promoted and interpreted as emotional detachment, impersonality, might well be the butt of the jibe, "Anyone who remains calm in the mist of this confusion just doesn't understand the situation." More to the point are the conclusions drawn by Henry Grunebaum, reported recently in the American Journal of Psychiatry on a survey of psychotherapists and what they wished in seeking therapy for themselves:[3] a warm and sympathetic therapist who would "respond to them as persons." More, Grunebaum concludes from his study, therapists should not try to treat anyone they cannot feel sympathy for. These conclusions obviously apply to social work clinical practice. We may need to examine our own resistance before tackling the client's. Therapy for client resistance is not commanding the action, defeating the resister, but first recognizing his distress, treating the wounds. If we try treatment first, we may not need to amputate.

When our lack of skill compounds the reluctant client's anxiety we become a source of additional stress rather than of comfort, strength, counsel. Our protective action without his consent may still be required, but psychologically, resistance in the client may spell failure of the therapist. Let us make sure the resistance of the client does not indict us. It would be too bad to lose the sweet rewards of earning an old and distraught client's trust and an easier transition to acceptance and comfort.

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[3]Grunebaum, Henry. Study of Therapists' Choice of a Therapist. Amer. Journal of Psychiatry, v. 140, m. 10, October 1983, p. 1336-1339.

In summary: As risk for the client increases, the social worker's responsibility to protect the client's welfare increases. The core of this responsibility is decision-making around the interventions necessary or indicated to shore up or substitute for the client's failing resources. In practice, clients facing diminution of their powers and of control over their lives often resist invasion of their lifestyle even as their own capacities and resources to maintain it are failing. This resistance may be rooted in: fear of what such changes in lifestyle presage in the uprooting of familiar surroundings or habits; avoiding or putting off facing painful changes; diminishing judgment for evaluating their own circumstances; cognitive impairment; hopelessness; or all of these and more. In any case, resistance is a major problem of work with declining old people who are fighting to retain control over their own lives and to overcome the forces of decline.

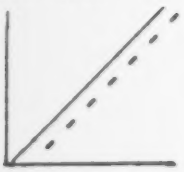
In clinical practice with resistant clients, we see that as their risk and needs rise, the difficulty in obtaining their participation in decision-making rises. Yet the greater their participation the healthier the likely outcome in restoring their sense of control over their own lives. In fact, the responsibility for himself resides in the client and only by default does responsibility fall to the social worker. Restoring this responsibility and authority to the client - in whatever measure his capacities will allow - also restores his control of his own life. This should be the goal of the treatment relationship.

With the declining aged, however, as their needs for support become more critical their defensive resistance may rise. As their resistance increases, and the more imperative our interventive services and changes become, the greater the requirement on the social worker for skill and effort. The

goal is to restore to them their authority and responsibility to decide what to do about themselves; or on the basis of trust to obtain their participation or at least consent to decisions for their welfare, made with them or for them; and finally, if nothing more, their permission or acquiescence to planning and carrying out the changes in their situation necessary to sustain them. Skill and the patience to allow the therapeutic relationship to develop is requisite to reducing fearful anxiety-based resistance and the underlying suffering, and to encourage the maximal utilization of the new services they require.

PSYCHODYNAMIC PATTERNS IN THERAPY OF RESISTANT CLIENTS

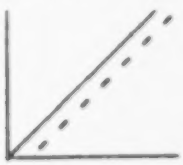
Client Risk



Worker Responsibility

Increased risk to the client requires increased worker responsibility

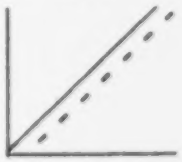
Client Risk



Client Resistance

The greater the risk, the higher the client's resistance

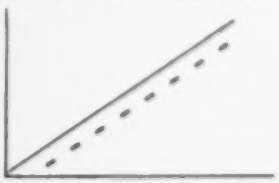
Client Risk



Worker Skill Required

The higher the risk to the client, the greater skill is required of the worker

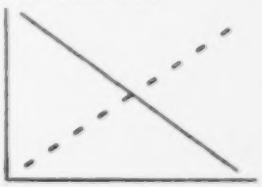
Therapeutic Relationship



Mutuality of Responsibility

The better the therapeutic relationship, the greater sharing of responsibility for decisions between client and worker.

Client Resistance



Therapeutic Relationship

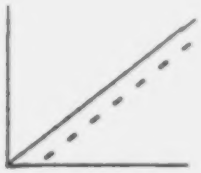
____ Client Resistance

- - - Therapeutic Relationship

The more therapeutic the relationship, the lower the client resistance.

Therapeutic Relationship

Complexity of Case



Team Consensus Required

The greater the complexity of the case, the more need for team consensus in decision-making

How Can We Guide Our Actions With At-Risk But Resistant Aged Clients?

To restate the professional task: the most sweeping decision in work with resistant clients is whether to intervene over their protests with intrusive service or institutionalization, or whether to respect their refusal to go along with such changes. The most critical diagnostic factor involved is the degree of mental-emotional intactness of the resistant client; the most critical treatment factor is the establishment of a therapeutic supportive relationship.

The resistive critically dysfunctional but intellectually intact client who refuses to enter an institution in preference to accepting the risks of remaining at home parallels the dying hospital patient on a life-support system, who understands the consequences but prefers to have the life-support system withdrawn, to die quickly and peacefully. One medical patient's wish has lately been legally honored in court because she was mentally competent and was in no doubt about her willingness to die.[4]

[4]Bouvia vs. County of Riverside, No. 159780 (Superior Court, California, 1984).

This parallel may help social workers decide when to honor a resistant, declining client's wish to remain outside an institution. The major criteria for respecting his choice may be listed as follows:

The client:

1. is mentally and emotionally balanced enough to function logically;

2. is terminal in the sense that any protective arrangements are just a matter of postponing approaching death;

3. is aware of the consequences of his refusal;

4. is certain of his preference to remain at risk rather than accept transfer, and who can work out some supportable arrangements for his remaining life at home with his own resources and outside help.

How to apply these principles, how to deal with less certain situations and how to use the therapeutic relationship with these dependent but contentious clients, is another chapter.